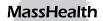
MassHealth Personal Care Attendant (PCA) Program

OVERTIME APPROVAL REQUEST FORM



THE COMMONWEALTH OF MASSACHUSETTS Executive Office of Health And Human Services

CONSUMER INFORMATION					
Consumer Name				Date of Birth	
MassHealth ID Number	PA I	PA Number			
Consumer ID Number		Consumer Phone Number			
Consumer Address	,				
Surrogate Name (if applicable)			Surrogate Phone (if applicable)		
PERSONAL CARE ATTENDANT PROVIDER INFORMATION					
PCA Name F		PCA U	PCA Unique Identifier/Provider Number		
PCA Address					
PCA Phone Number					
REQUEST OVERTIME APPROVAL TYPE					
Consumer Living with PCA (consumer approved for 40-60 hours per week) (go to SE			IA) Contir	uity of Care Short-Term (go to SECTION B)	
The consumer must be approved for 40-60 hours per week consumer. Please provide documentation that you and you				A must be the only PCA working for the	
PROOF OF RESIDENCY REQUIRED DOCUMENTS:					
Must include a minimum of two for the PCA. Documents m PCA name and address must be on 2 documents below (select and at				nd not a PO Box.	
Gas/Oil bill - no older than three months	er than three months				
Water bill - no older than three months			ty tax bill or rece	•	
Electric bill - no older than three months				ial rental contract (apartment lease or other rental of	
Cable TV bill - no older than three months		·	. , ,	and signed verification letter from landlord)	
Phone bill - no older than three months			-issued identification		
Current homeowner's or renter's insurance certificate			Change of address confirmation from U.S. Postal Service		
Current automobile insurance certificate			Other form or documentation that contains information identifying the PCA's name and residence		
Vehicle registration title		uie ru	12 Hallie allu 162	IUCIICC	

SECTION B: CONTINUITY OF CARE SHORT-TERM

	ast work more than 40 hours per week to avoid a disruption in care a description of your request below. If additional space is required,
Select One: I am the only consumer my PCA works for. My PCA works for me and other PCA consumers more to Describe	han 40 hours per week.
Total number of hours/week requested for PCA to work	
ATTESTATION ORIGINAL SIGNATURES REQUIRED	
CONSUMER/SURROGATE	
may be subject to civil penalties or criminal prosecution for contained herein. This documentation will be retained by	ation contained herein is true and accurate. I understand that I or any falsification, omission, or concealment of any material fact my PCM Agency in my record and in the event of an audit, the all medical records of MassHealth Consumers corresponding to, or 0 CMR 422.000 and 130 CMR 450.204 and 450.205.
I WILL NOTIFY MY FISCAL INTERMEDIARY IMMEDIATELY IF I HIRE ADDI	TIONAL PERSONAL CARE ATTENDANTS OR IF MY LIVING CIRCUMSTANCES CHANGE.
Consumer Signature	Date / /
Surrogate Signature (if applicable)	Date / /
PERSONAL CARE ATTENDANT	
may be subject to civil penalties or criminal prosecution for contained herein. This documentation will be retained by	ation contained herein is true and accurate. I understand that I or any falsification, omission, or concealment of any material fact the PCM Agency in the consumer's record and in the event of an any and all medical records of MassHealth consumers corresponding th 130 CMR 422.000 and 130 CMR 450.204 and 450.205.
PCA Provider Signature	Date / /
PERSONAL CARE MANAGEMENT AGENCY	
I certify, to the best of my knowledge, that the information	on this form is true, accurate, and complete.
PCM Agency Name	
PCM Agency Signature	Date: / /
If SCO or One Care is checked, fill in:	oval Start Date / / End Date / /

INSTRUCTIONS FOR CONSUMER/SURROGATES TO FILL OUT OVERTIME REQUEST FORM

In accordance with the MassHealth PCA regulation at 130 CMR 422.420(A)(5)(b), consumers are required to ensure that each PCA works no more than 40 hours per week unless the consumer is approved for a time limited approval to schedule overtime pursuant to 130 CMR 422.418(C). PCAs are required to adhere to the weekly hour limit or approved overtime hours in accordance with the MassHealth PCA regulations at 130 CMR 422.419(C)(3) and (4) and may be subject to sanctions for violating this provision, including suspension or termination.

INSTRUCTIONS FOR FILLING OUT AND SUBMITTING THIS FORM

You, the consumer or surrogate, if applicable, must fill out this form and make copies of any required documentation. To request assistance in filling out this form, contact your PCM Agency.

Submit this form and required documentation to your PCM Agency.

CONSUMER INFORMATION

Fill in your information to include your name, address, phone number, MassHealth ID number, consumer ID number, date of birth and PA number. If you have a surrogate, include your surrogate's name and phone number.

PERSONAL CARE ATTENDANT INFORMATION

Fill in your PCA's information to include name, address, phone number, and PCA Unique Identifier/Provider Number, located on your PCA's Activity Sheet. If you do not know your PCA's Unique Identifier/Provider Number, contact your fiscal intermediary.

REQUEST OVERTIME TYPE

Indicate which overtime request you are seeking. If you are approved to schedule overtime, the number of approved hours will not exceed the amount of your approved prior authorization hours.

Consumer Living with PCA. This request to schedule overtime may apply if you meet all of the following:

- 1) A consumer has been approved by MassHealth to schedule more than 40 but less than 60 hours per week of personal care services,
- 2) The consumer lives in the same home as the PCA, and
- 3) The consumer receives all of his or her care from that one PCA.

If approved, the consumer living with PCA request to schedule overtime will be valid for the consumer's prior authorization period and must be validated every year.

Continuity of Care Short-term. This request to schedule overtime may apply if you meet the following:

The consumer requires his or her individual PCA to work more than 40 hours per week for a short-term basis to avoid a disruption in care while the consumer seeks additional PCA(s) and adjusts the number of hours the PCAs work the consumer.

SECTION A: CONSUMER LIVING WITH PCA REQUEST

Provide a copy of two different required documents from the list for your PCA. All documents must have the same address physical street address (not a PO Box) and the PCA's name must be listed on both documents.

SECTION B: CONTINUITY OF CARE SHORT-TERM REQUEST

Select one of the two reasons for your Continuity of Care request. Explain in detail the reason your PCA must work more than 40 hours per week to avoid a disruption in your care while you seek additional PCAs. Fill in the total number of hours per week you are requesting for your PCA to work. The number of hours cannot exceed the total amount of your approved prior authorization hours. If additional space is required, please attach signed and dated document to the form.

ATTESTATION

CONSUMER/SURROGATE

You and your surrogate, if any, must sign and date the form and must certify that all information contained within the form is true, accurate, and complete.

PERSONAL CARE ATTENDANT

Your PCA must sign and date the form and must certify that all information contained with the form is true, accurate, and complete.

PERSONAL CARE MANAGEMENT AGENCY

The PCM Agency representative must fill in the PCM Agency name, sign and date the form and certify that the information is true, accurate, and complete to the best of the PCM Agency's knowledge. The PCM Agency must select if the consumer is enrolled in Fee for Service (FFS), Senior Care Options (SCO) or One Care. If the consumer is enrolled in SCO or One Care, fill in the approved number of hours per week (day/eve plus night) and SCO or One Care approval start and end date.